Audit of the Management of Billings and Collections for the Department of Health's Outpatient Adult Mental Health Services

A Report to the Governor and the Legislature of the State of Hawaii

Report No. 95-25
November 1995

THE AUDITOR
STATE OF HAWAII

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OVERVIEW

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Summary

The State Auditor initiated this audit to assess the management of billings and collections for outpatient adult mental health services provided by the Department of Health through eight state-run community mental health centers and a purchase of services contract with the Waianae Coast Community Mental Health Center, Inc., a private, nonprofit organization. We also examined oversight of billings and collections by the department's Adult Mental Health Division.

While state-run centers are steadily increasing their revenues from billings and collections, obstacles and varying commitments hinder the maximization of these revenues. In FY1992-93, the state centers recouped only $124,608 of the expected $248,448. Current recoupment falls far short of initial estimates that each center generate 30 to 40 percent of its budget from Medicaid billings. In FY1993-94, billing revenues amounted to $338,209, or about 3 percent of the $11.7 million in general funds allocated to the state centers.

A variety of obstacles contribute to the lower than anticipated revenue recoupment. These include staff vacancies at the centers, insufficient automation, lack of formal training, and insufficient guidance from the Adult Mental Health Division. State centers also vary in staff commitment to billing and in management controls. The subaccount expenditure ceiling for each state center within the department's Mental Health and Substance Abuse Special Fund, into which the centers' revenues are deposited, needs re-evaluation so that the centers will not be discouraged from pursuing revenues.

The Adult Mental Health Division, to which the state centers report, has not aggressively pursued the maximization of their billings and collections. The division has provided no overall plan or guidelines, little formal training, weak oversight, and inadequate recordkeeping. It has not pursued all revenue opportunities, including collecting from individual clients and private and government insurers, and lacks a qualified, knowledgeable billing coordinator.

Finally, the lack of adequate automation hampers the ability of the state centers to maximize billings and collections. Problems exist with both hardware and software. The Adult Mental Health Division has not met the computer needs of the centers.

Recommendations and Response

We recommend that the chiefs of the state-run community mental health centers make maximizing billings and collections a top priority. Management should also implement controls to ensure that staff complete all necessary procedures, forms, and records for billings and collections. The Adult Mental Health Division should re-evaluate and adjust the centers' special fund subaccount ceilings within the legislative appropriation for the special fund.

We also recommend that the division adopt an aggressive, pro-active role and assume its responsibilities in guiding, supporting, and monitoring the state centers' billings and collections. Specifically, the division should plan and implement a division-wide, overall billing system for the centers, including proper automation, standard policies and procedures, management controls, and an on-going training program. The division should designate a qualified staff member to concentrate on implementing the division's billing and collection responsibilities, who would serve as a resource person, coordinator, and advocate for the division and the centers. The division should maintain proper documentation and historical information crucial to the division's billing and collection efforts.

The division should also purchase an integrated billing computer software package that will meet at least the requirements identified in our report, and provide ongoing training and technical support for the package. The division should install comparable computer hardware at all of the state centers to support an on-line, integrated billing system.

The Department of Health responded that, overall, it is in agreement with our findings and recommendations. It found our report to be objective and fairly presented. We made a few changes in the final report to address factual issues raised by the department. The department also reported reimbursements of $1,195,019 for FY1994-95 due to recent revenue-generating activities.

The Waianae center did not submit a response.

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Submitted by

THE AUDITOR
STATE OF HAWAII

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Foreword

This audit of the management of billings and collections for outpatient adult mental health services of the Department of Health was performed pursuant to Section 23-4, Hawaii Revised Statutes, which requires the State Auditor to conduct post-audits of the transactions, accounts, programs, and performance of all state agencies.

We wish to express our appreciation for the cooperation and assistance of officials and staff of the Department of Health, its community mental health centers, and the Waianae Coast Community Mental Health Center, Inc. We also appreciate the assistance of personnel of the Department of Human Services, insurers, and private medical organizations that we contacted for information.

Marion M. Higa
State Auditor

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Chapter 1
Introduction

The State Auditor initiated this audit to assess the management of billings and collections for outpatient adult mental health services provided by nine community mental health centers connected with the Department of Health. Eight of the centers are run by the department. The other is a private, nonprofit center that provides services under a purchase of services contract with the department.

The audit was performed pursuant to Section 23-4, Hawaii Revised Statutes, which requires the Auditor to conduct post-audits of the transactions, accounts, programs, and performance of all state agencies.

Impetus for the Audit

Adult mental health services provided by the community mental health centers are funded by the state general fund and by fees and third-party reimbursements for services provided. Third-party reimbursements may include payments from government programs such as Medicaid, Medicare, the new Hawaii Health Quest program of the Department of Human Services, and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); and from private insurers such as the Hawaii Medical Service Association (HMSA), Island Care, and Travelers.

In January 1984 we issued a report titled *Budget Review and Analysis of the Mental Retardation and Mental Health Programs*, Report No. 84-9. We reported that both the fees charged by the state-run community mental health centers and the collection of fees varied from center to center. We recommended that the Department of Health establish equitable fees by rule and create fair procedures to determine ability to pay for services. In 1991, the department set a standardized fee schedule, by rule, for all of its centers.

In recent years, concerns have been expressed about the amount of fees or third-party reimbursements collected by the state centers. A 1991 survey by the National Council of Community Mental Health Centers indicated that, nationwide, centers received approximately 16 percent of their revenues from Medicaid.[1] Yet in FY1991-92, three centers in Hawaii did not collect any Medicaid payments, while others collected only between $1,200 and $14,000 apiece from Medicaid.

In 1992, the Adult Mental Health Division of the department, to which the state centers report, ordered these centers to bill for services. While revenues from billings have increased significantly since FY1991-92,

these revenues are small in proportion to the general fund allocations to the centers. For FY1993-94, billing revenues of the state centers totaled $338,209, while general fund allocations totaled $11.7 million.

In Act 289, Session Laws of Hawaii 1993 (the General Appropriations Act), a legislative proviso (Section 43) pertaining to the general fund appropriation for adult mental health (HTH 420) for FY1994-95 required the department to generate Medicaid billings of (1) two dollars for every five dollars in operating funds that qualified for Medicaid billing and (2) the same amount for any additional funds redirected or appropriated to the Medicaid eligible activities of the Adult Mental Health Division.

This report presents background information and our findings and recommendations on the management of billings and collections for outpatient adult mental health services by the community mental health centers and the Adult Mental Health Division.

Background on Community Mental Health Centers

Act 218, Session Laws of Hawaii 1984, amended Section 334-3, Hawaii Revised Statutes, to require the Department of Health, within the limits of available funds, to provide for the establishment of a community-based mental health system for Hawaii that would be responsive to the needs of persons of all ages, ethnic groups, and in all geographic areas. Among other things, Section 334-3 requires that the system offer community-based, relevant, and responsive outpatient services; case management, outreach, and follow-up; emergency crisis and noncrisis intervention; psychiatric hospitalization; and rehabilitative services.

The Behavioral Health Administration of the department administers its mental health programs. Under this administration, the Adult Mental Health Division directs, coordinates, and monitors the operations of the State's adult mental health programs, services, activities, and facilities. Eight community mental health center branches, a courts and corrections branch, and the Hawaii State Hospital (a psychiatric facility) fall under the division. The eight community mental health centers that report to the division are the Central Oahu, Diamond Head, Kalihi-Palama, Leeward Oahu, Windward Oahu, Hawaii County, Maui County, and Kauai County centers. All eight centers and a purchase of service contract with the private center are funded under Program ID HTH 420—Adult Mental Health—in the state budget.

In the State's official organizational charts, the Maui, Kauai, and Hawaii centers fall not under the division but under their respective district health offices of the Department of Health. However, by practice and in accordance with the division's responsibilities outlined in the State's functional statements for the department, these centers report to the division.

The division also contracts with the Waianae Coast Community Mental Health Center, Inc., a private, non-profit organization, to provide services to the residents of the Waianae coast of Oahu.

Services

These centers serve as focal points for the development, coordination, and delivery of adult mental health services in their geographic areas. They provide outpatient services to those who are seriously mentally ill, in severe acute mental health crisis, or experiencing stress from a disaster. Services include outpatient therapy, case management, bio-psychosocial rehabilitation, and emergency/crisis intervention.

Accreditation

Around the time of this audit, four of the centers received three-year accreditation from the Commission on Accreditation of Rehabilitation Facilities, which accredits community mental health centers nationally. The Waianae Coast and Windward Oahu centers now are accredited for outpatient therapy and mental health case management. The Diamond Head center is accredited for outpatient therapy, mental health case management, and psychosocial rehabilitation programs. The Kauai County center is accredited for all of these services and also for emergency/crisis intervention services.

General funds

Exhibit 1.1 shows general funds appropriated and allocated for FY1993-94 and FY1994-95 to each state community mental health center. Allocations represent the actual amounts available for expenditure.

The only federal funding received by a state center was $75,266 to the Central Oahu center for FY1993-94 from a block grant held by the Adult Mental Health Division. (This grant is not reflected in Exhibit 1.1.)

The contract with the Waianae Coast Community Mental Health Center, Inc., is set at $1,163,800 for FY1993-94 and $1,177,035 for FY1994-95 for mental health services to adults and children. Approximately $635,000 is budgeted for services to adults for FY1993-94 and $650,000 for FY1994-95.

Fees and reimbursements

Section 334-6, HRS, requires the Department of Health through its director of health, to establish reasonable charges for mental health treatment services and makes persons receiving treatment and their spouses liable for treatment expenses. However, the law makes collecting such fees from clients discretionary with the director. No collections are to be made if the client cannot afford to pay.

Exhibit 1.1
State-Run Centers' Fiscal Biennium1993-95 Budgets

Center	Appropriated FY1993-94	Allocated FY1993-94	Appropriated FY1994-95	Allocated FY1994-95
Central Oahu	$ 1,373,419	$ 1,362,430	$ 1,317,795	$ 1,196,189
Diamond Head	1,975,387	1,958,884	1,848,187	1,804,120
Kalihi-Palama	1,713,599	1,699,906	1,594,859	1,462,483
Leeward Oahu	1,062,876	1,055,645	1,005,576	921,113
Windward Oahu	1,458,757	1,447,683	1,380,473	1,273,217
Hawaii County	1,355,231	1,620,446	1,327,650	1,370,727
Maui County	1,371,502	1,360,217	1,313,702	1,257,555
Kauai County	1,223,389	1,214,465	1,169,614	1,128,091
Totals	$ 11,534,160	$ 11,719,676	$ 10,957,856	$ 10,413,495

Source: Department of Health, Adult Mental Health Division

Special fund

Client and insurer payments received for treatment services of the state centers are deposited into the department's Mental Health and Substance Abuse Special Fund under Section 334-15, HRS. The special fund contains a separate account for each of the state centers. The Legislature's appropriations for the special fund for fiscal biennium 1993-95 is set by law at $584,981 for each fiscal year—that is, the centers may spend up to the appropriated amount should they generate that amount in revenues.

Sources of billing revenues

Through the end of March 1995, Medicaid revenues made up about 63 percent of total billing revenues for all of the state centers during FY1994-95, although as of April 1995, only about one-third of all clients had Medicaid as their primary insurer. Medicare followed with about 26 percent of billing revenues; 31 percent of the clients had Medicare as their primary insurer. Other insurers, not including the new Hawaii Health Quest program, provided 10 percent of revenues. These other insurers included private insurers (covering 14 percent of the clients). Health Quest (covering 11 percent of the clients) had not yet paid any reimbursements to the centers up through March 1995.

About 10 percent of all clients were uninsured. Only the Central Oahu, Diamond Head, and Kauai County centers collected direct payments from patients. This represented 0.2 percent of the total revenues (not including out-of-pocket payments collected for COPE, a preventive education program unique to the Central Oahu center).

Staffing

Staffing at the centers may include psychiatrists, psychologists, social workers, nurses, and clerical and administrative employees, such as billing clerks. Some staffing needs are met by hiring workers on a fee-for-service basis. Exhibit 1.2 provides a profile of positions authorized by the Legislature through general fund appropriations and those actually allocated to the state centers in FY1994-95. Twenty-six percent of all positions allocated to the centers were vacant in March 1995.

Exhibit 1.2
Centers' Budget FY1994-95 Positions and Vacancies

State Center	Positions Appropriated	Positions Allocated	Vacancies in March 1995
Central Oahu	35	30	8
Diamond Head	56	47	6
Kalihi-Palama	43.5	38.5	8
Leeward Oahu	27	23	7
Windward Oahu	36.5	34.5	10
Hawaii County	39	38	11
Maui County	36	33.5	15
Kauai County	29	27.5	7
Totals	302	272	72

Source: Department of Health, Adult Mental Health Division

Clients served

The state centers served a total of 4,638 clients in FY1993-94; 3,934 clients were served in FY1994-95. The Waianae Coast center served 272 adults in FY1993-94, and 247 adults in FY1994-95.

Objectives of the Audit

The audit had the following objectives:

1. Assess the management practices of the Department of Health's community mental health centers for collecting fees and reimbursements for outpatient adult mental health services provided.

2. Evaluate the Adult Mental Health Division's management oversight of the centers' billings and collections for services provided.

3. Make recommendations as appropriate.

Scope and Methodology

To accomplish these objectives, we visited the nine community mental health centers. We assessed the eight state centers more closely than the private Waianae center. We looked at management practices, including policies and procedures and their implementation, for charging fees and for collecting fees and third-party reimbursements. In addition, we reviewed the implementation of the Department of Health's clinic rate schedule for outpatient adult mental health services and the extent of billings and collections for these services. We also examined billing problems involving various insurers and the centers' computer capabilities. We conducted interviews and reviewed documents and a limited sample of randomly selected case files at each center.

We examined the Adult Mental Health Division's oversight of all centers' billings and collections. In addition, we conducted interviews and reviewed documents at the division and at the offices of the Behavioral Health Administration, but few documents were available.

Our work included other interviews and inquiries with personnel of the Medicaid and Medicare programs, and the Hawaii Health Quest program and its Behavioral Health Managed Care plan. For information on private sector billing and collection practices, we also interviewed personnel from a few private medical organizations that provide outpatient services.

We reviewed relevant state statutes and administrative rules and legislative documents, and gathered information on budgets, billing revenues, and personnel vacancies.

Our work was performed from January 1995 through September 1995 in accordance with generally accepted government auditing standards.

Chapter 2

Findings and Recommendations

In this chapter, we examine the billing and collection efforts of the community mental health centers and Adult Mental Health Division of the Department of Health. In light of the State's current budget crunch, it is more important than ever that the division and the centers make billings and collections a top priority.

Summary of Findings

1. The state-run community mental health centers are steadily increasing their revenues from billings and collections, but obstacles and varying commitments hinder the maximization of these revenues.

2. The Adult Mental Health Division has not aggressively pursued the maximization of billings and collections of the community mental health centers.

3. The lack of adequate automation presents a major obstacle to the ability of the state centers to maximize billings and collections.

State Community Mental Health Centers Struggle to Maximize Billings and Collections

Billing for services provided should be a basic activity of the community mental health centers. Section 334-6, Hawaii Revised Statutes, requires the Department of Health to establish reasonable charges for services provided at the centers and holds persons receiving services and their spouses liable for these costs. The law also gives the department discretion to collect based on the financial status of the clients and their families. Functional statements for the Adult Mental Health Division of the department and the community mental health center branches describe responsibilities that include maintaining a system of billing for the payment of fees or receipt of third-party reimbursements from insurers such as Medicaid, Medicare, and private insurers.

Revenues raised through billings and collections support client services by helping to pay for operating expenses. Charging for services, as is done in the private sector, may also make it more likely that clients will value these services.

Currently, all of the community mental health centers bill for at least some of the services that they provide. Revenues from billings have steadily increased over the last three years. However, a number of

factors prevent the maximization of billing revenues at the state-run centers, including staff vacancies, limited automation, lack of training, and varying commitments to billing. Center staff are struggling, with some success, to overcome these obstacles. Additional efforts, including stronger support from the Adult Mental Health Division, are needed.

Billing history is unclear

The state centers initiated their billing with the Medicaid program and gradually expanded to other insurers. It appears that prior to 1992, state centers billed inconsistently for their services. But little documentation on billing exists at the Behavioral Health Administration, the Adult Mental Health Division, or the centers, from which to trace precisely the history of billing and collection efforts. Furthermore, conflicting information exists.

In their joint November 1990 report to the Legislative Auditor entitled *Progress Report on Maximizing Federal Medicaid Funds for Hawaii*, the Department of Health and the Department of Human Services commented that "all mental health centers were billing for Medicaid services by October 1st and will bill for other third party payment by the end of 1990." The Adult Mental Health Division informed us that five state centers received Medicaid reimbursements totaling $32,896 from July 1, 1991 to June 30, 1992. Four of the centers report some billing activity, probably for Medicaid reimbursements, in the late 1980s and early 1990s.

However, a Legislative Reference Bureau (LRB) report, *"Reinventing" Governance of Hawaii's Public Mental Health Delivery System—Problems, Options, and Possibilities* (Report No. 5, 1994), states that in 1991, the community mental health centers did not bill Medicaid for reimbursable services. According to the LRB report, during the 1992 legislative session, one legislator said that the centers had been promising to bill Medicaid for years but had refused to do so. The report also said that the Department of Health committed itself and the centers to pursuing Medicaid billing in the 1992 calendar year.

In reviewing documents at the state centers, we found that in 1992, the Adult Mental Health Division provided each center with a start date for billing that ranged from February 1992 to April 1993. The start date was based on the division's assessment of each center's operations in the areas of staffing, clinical practices, record-keeping, and quality assurance. Then, in late November 1992, the division issued an order to the centers to implement the pursuit of revenue recoupment (billing) immediately. All centers, at various points in time, began with Medicaid billings. By mid-1993 all centers were billing Medicaid.

Billing revenues are steadily increasing

All clients at all centers receive services regardless of their ability to pay. Currently, all the state centers bill Medicaid and Medicare, although some centers are behind in these billings. Most of the centers also bill at least one private insurance company. The Kauai County center bills all private insurers. Kauai also actively pursues out-of-pocket payments from clients for non-covered services and co-payments. Only two centers, Diamond Head and Maui County, have their own collection policies, but even these are not consistently enforced.

Waianae Coast Community Mental Health Center, Inc., has been developing its own billing system, which is computerized to a larger extent than the state centers' systems. The Waianae center pays 6 percent of its collected revenues to the Waianae Coast Comprehensive Health Center to issue and collect on the mental health center's claims. Waianae does not presently bill private insurers (it has few clients with private insurance).

The state centers' billing revenues have been steadily increasing, starting with the Medicaid program and gradually expanding to other insurers. At our request, the division provided us with figures for revenue deposits beginning with FY1991-92 (see Exhibit 2.1). We used the figures for FY1991-92 as a baseline, since revenues received in that fiscal year were generated prior to the division's November 1992 order to bill.

Exhibit 2.1
Collections of State-Run Centers

	FY1991-92	FY1992-93	FY1993-94	07/01/94 - 03/31/95
Central Oahu	$ 1,199	$ 5,460	$14,792	$ 50,526
Diamond Head	0	39,583	63,234	107,904
Kalihi-Palama	13,625	6,132	33,088	68,965
Leeward Oahu	2,670	2,772	10,879	14,673
Windward Oahu	9,257	5,368	26,148	33,685
Hawaii County	0	0	27,742	57,929
Maui County	6,145	29,900	71,744	88,664
Kauai County	0	35,393	90,582	85,420
Totals	$ 32,896	$124,608	$338,209	$507,766

Source: Department of Health, Adult Mental Health Division

The division reports that the centers received Medicaid revenues totaling $32,896 in FY1991-92. During that year, the Diamond Head, Hawaii County, and Kauai County centers received nothing. However, in the following year, billing revenues increased over the baseline year by $91,712 or 279 percent. In FY1993-94 these revenues increased over the baseline year by $305,314 or 928 percent. For the first three quarters of FY1994-95, billing revenues increased by $474,870 over the baseline year or 1,444 percent.

As of the third quarter of FY1994-95, all of the centers have received reimbursements from both Medicaid and Medicare. In this year, Medicaid provided approximately 63 percent of total reimbursement dollars. Revenues from Medicare (26 percent) and other, including private, insurers (10 percent) increased from previous years.

Obstacles prevent revenue maximization

Despite these increases, the centers are not maximizing their billings and collections. The Adult Mental Health Division expected the state centers to recoup $248,448 in FY1992-93. Actual billing revenues totaled $124,608. Current recoupment falls far short of initial estimates that each center would generate 30 to 40 percent of its budget from Medicaid billings.[1] In FY1993-94, all billing revenues from all insurers amounted to only 3 percent of the general funds allocated to the centers.

A variety of obstacles contribute to the lower than anticipated revenue recoupment. These include staff vacancies at the centers, insufficient automation, and lack of formal training. These limitations in billing resources diminish the capability of the centers to bill for all services in a timely manner and to collect reimbursements and fees. Late claims may result in no payments or discounted payments from insurers.

Staff vacancies

Staff vacancies at the centers weaken reimbursement efforts. For example, currently, the state centers have numerous vacant positions for psychiatrists, clinical psychologists, and social workers. This is due to the current gloomy financia! situation of the State and Act 212, Session Laws of Hawaii 1994, which provides an early retirement incentive for state employees. Many positions remain vacant because of a lack of funds or a hold on recruitment. Also, some positions have also been abolished.

Services provided by psychiatrists, psychologists, and social workers may be billed to insurers as well as to clients. For example, all insurers reimburse for psychiatrists' individual psychotherapy services at the centers. However, four centers have vacant psychiatrist positions and another operates without an established psychiatrist position. These

centers use fee-for-service psychiatrists at a higher cost. The additional costs are not recouped through billings because these services are reimbursed by insurers at the same rates as those of state-employed psychiatrists.

Staff vacancies also have a ripple effect on billing operations. The centers all depend on time-consuming, labor-intensive, largely manual billing processes for which the billing clerk has the main responsibilities. Due to vacancies or lack of positions in clerical and administrative staff at the centers, several billing clerks perform additional non-billing duties such as answering phones, typing, making patient appointments, overseeing the medical records, or inputting information into MFASIS, the management information system of the Adult Mental Health Division. Because they cannot devote their full attention to the billing process, some of the billing clerks face backlogs in filing claims and updating records. This can reduce overall reimbursements because insurers place limits on retroactive billing and may discount reimbursements (like Medicare) for claims filed after a specific period of time.

Limited automation

Manual, labor-intensive processes resulting from the lack of sufficient automation dominate the billing systems of the state centers. This contributes to the backlogs.

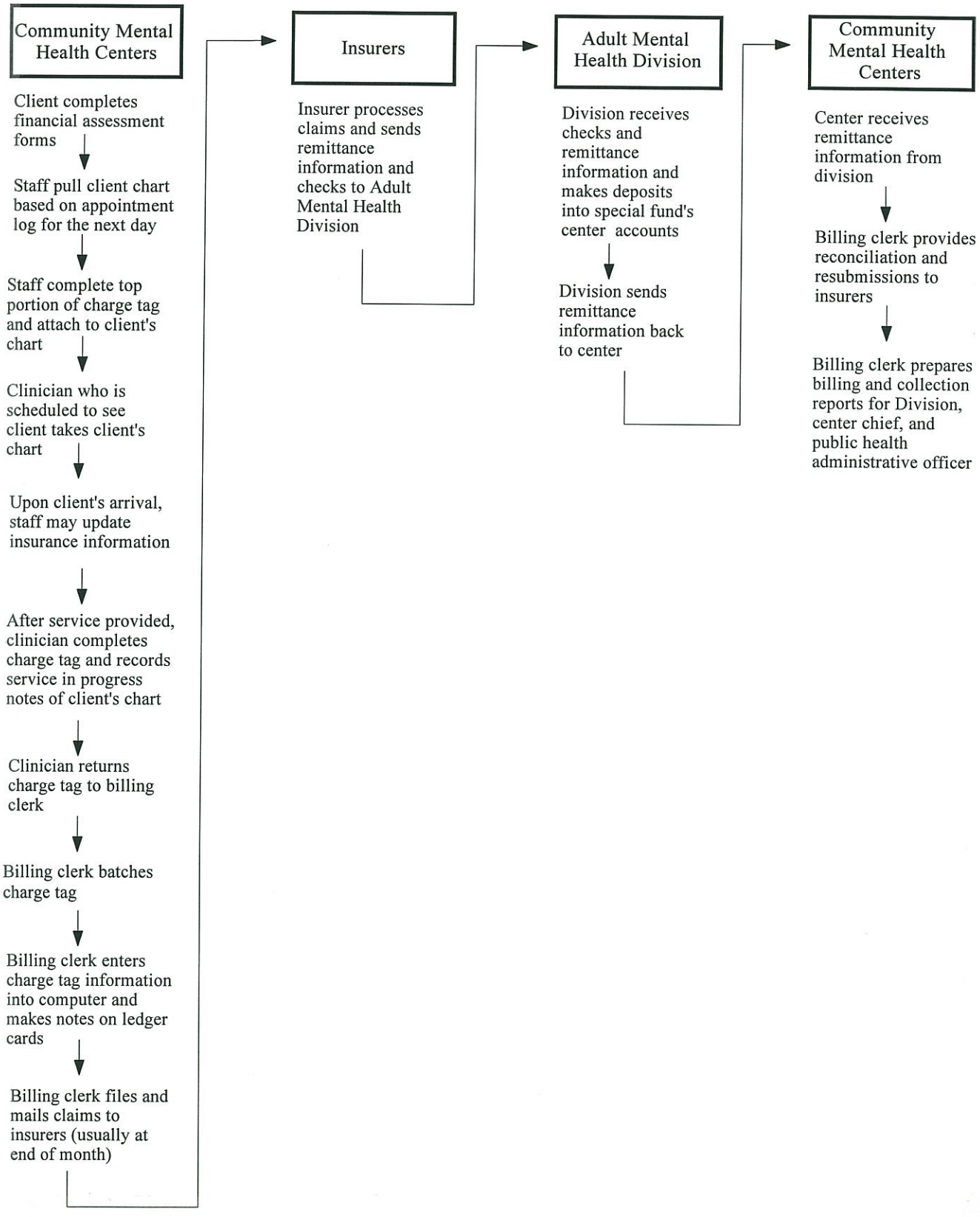
Each community mental health center (including Waianae) has created its own unique billing system. However, all the state-run centers rely on a manual process. Exhibit 2.2 is a flowchart of billing procedures common to the state centers for most of their services.

With the assistance of center staff, new clients complete financial assessment forms, including information on insurance coverage. The financial assessment form may be updated when the client comes in for appointments.

Paper charge tags (or as with one center, client service forms) serve as the basic document for billing. The billing clerk and service provider manually complete a charge tag each time a service is provided to a client. Charge tags for case management services may be prepared at the end of the month with a listing of case management services provided in that month (a variation from the process described in the flowchart).

Prior to a client's appointment, the billing clerk usually pulls the client's chart and attaches a charge tag to it. The chart with the charge tag goes to the service provider. After the service is completed, the provider describes the service provided on the charge tag and signs the tag. The provider also enters information on the services in the progress notes maintained in the client's chart and signs the entry.

Exhibit 2.2
Billing Process of State Centers for Most Services



The charge tags then go back to the billing clerks. At most centers, the clerks input the service information into the billing software program provided by the Adult Mental Health Division.

Most billing clerks also maintain individual paper ledger cards or sheets for clients, detailing information such as dates of service, provider names, procedure codes, amounts billed, and remittances received. At many centers, these ledgers contain the most comprehensive description of billing for services provided.

Claims are generally sent to insurers at the end of the month. The billing software prints the HCFA 1500 form that serves as the basic claim form for most insurers. However, because the software has limitations, billing clerks report that manual changes must be made to the form to meet the requirements of insurers, except for Medicaid.

Reimbursements from insurers are sent directly to the Adult Mental Health Division. The money is deposited into the appropriate center's account in the department's Mental Health and Substance Abuse Special Fund. Information on these remittances is sent to the centers. Billing clerks post the remittance information onto both the computer software and the manual ledger cards.

With patient caseloads of several hundred annually at each center, the dependence on manual processes makes billing and collecting inefficient and sometimes ineffective. Billing clerks told us of backlogs in filing claims. Backlogged claims may lead to discounted or totally rejected claims. From our review of a selected sample of billing files at each center, it also appears that many of the billing clerks do not keep their paper ledgers up to date, resulting in incomplete billing and collection records.

On-the-job training

The limitations of on-the-job training also hinder the centers' ability to bill and collect revenues. It appears that few of the billing clerks had any billing experience prior to working at the centers and the division provided little formal training. Clerks learned each insurer's billable services and claims processes in bits and pieces through monthly meetings of the billing clerks, trial and error, consultation with billing clerks at other centers, and occasional training sessions organized by the division. This method of learning is slow and inefficient. Furthermore, there is no assurance that the information obtained or shared is accurate or consistent.

Insufficient guidance

The billing clerks have insufficient written guidance because policies and procedures for billings and collections are nonexistent or limited at some centers and not implemented by the division. Instead, the division has issued memos on a case-by-case basis in response to billing questions. The Behavioral Health Administration, overseeing the division, contracted with the firm of Ernst & Young to develop a billing and collection manual, but never implemented it.

Furthermore, significant billing issues arise that require the billing clerks to search for answers or a resolution. For example, there has been a problem in processing claims between Medicare as the primary insurer and Medicaid as the secondary insurer. There has also been a problem in obtaining reimbursements for case management services when Medicaid is the secondary insurer. These issues need to be resolved for all centers, not on a center-by-center or case-by-case basis.

While sharing and collaboration among billing clerks in working on these issues is a commendable effort, it is not always efficient. If the division would provide appropriate expertise, coordination, and advocacy for the centers, billing clerks would not have to devote as much time to billing issues. Their efforts could be better used to bill more timely and comprehensively.

Centers' staff vary in commitment to billing

Although each state center maintains that billing is a priority, some staff at the centers have resisted billing. Staff must realize, nevertheless, that billing revenues support quality services. In addition to general funds, centers now use billing revenues to pay for operating costs, medication for indigent patients, fee-for-service contracts, and on-call emergency services. Centers will become increasingly dependent on billing revenues to maintain services if the State's budgetary situation does not improve.

Commitment to billing crucial

Some clinical staff seem to have resisted billing because of a philosophy that the centers should be a safety net providing outpatient mental health services to everyone who requires them. Apparently they felt that this justified not having to focus on billing. However, this philosophy may be changing as staff realize that the centers are becoming more dependent on billing revenues to make services possible.

For a successful billing program that supports services to clients, center staff need to be committed to billing for all services provided to every client. This includes strong direction from the chiefs and staff commitment to billing even while striving for national accreditation.

The center chiefs, as administrative heads, must provide leadership and show strong commitment by being actively involved in the billing process. The chiefs can establish the overall direction of billing and encourage, supervise, and oversee the billing and collection process. They play an integral role in the billing system, serving as liaisons for the billing clerks to both the Adult Mental Health Division and the clinical staff. Chiefs oversee the clinical staff who are responsible for documenting the services provided. Proper treatment documentation is needed to justify claims submissions.

Our review of case files and internal memoranda generally revealed numerous instances where the absence of required pre-authorizations, or the failure of staff to complete charge tags or other proper documentation, prevented centers from receiving more reimbursements.

To correct this situation, all center chiefs should establish management controls. For example, three centers—Windward Oahu, Kalihi-Palama, and Diamond Head—have implemented controls. The duties of the quality assurance committee at Windward Oahu include verifying that the clinical files contain documentation to support billing. At Kalihi-Palama, the clinical clerical staff compare client progress notes to charge tags and make sure the charge tags are completed correctly before forwarding them to the billing clerk. At Diamond Head, the billing clerk checks the charge tags against the progress notes to make sure that the tags reflect the services provided and checks on whether tags are done as services are provided.

It is also important for each center to consistently conduct periodic reviews of all aspects of its billing process. A quality assurance committee or other committee formed at the center can carry out this function.

Recently, the main focus of the centers, and of the division with regard to the centers, has been obtaining accreditation from the national Commission on Accreditation of Rehabilitation Facilities. According to the division, accreditation means that the centers meet the standards for quality service. The accreditation process requires many hours of work. Three of the state centers recently received accreditation while the other five have yet to complete the process.

The accreditation process may have shifted attention away from the importance of billings and collections. But the division and centers need to increase billing revenues even while striving for a higher quality of services.

Commitment increases revenues

A strong commitment to billing leads to increased revenues. As an example, the Kauai County center consistently ranks among the top three centers for collecting reimbursements. Kauai County not only submits claims to all private insurers but also consistently attempts to bill clients for out-of-pocket costs and co-payments, collecting $1,767 from clients during the last two years. While this amount may seem insignificant, it does reflect the creative efforts of the center. Center staff informed us that because the software provided by the division cannot produce billing statements to clients directly, the HCFA 1500 insurance claim form is used for this purpose.

At the Maui County center, also one of the most productive centers in collecting reimbursements, the center chief has taken a strong stance with staff on maintaining proper documentation for billing. The center's policies and procedures emphasize the importance of billing. Memoranda from the chief reinforce this, for example by calling individual clinical staff to task for delays in documentation.

Another example of commitment is provided by the former chief of the Diamond Head center, who actively participated in the billing process by establishing policies and procedures to guide billings and collections and who encouraged staff to consistently bill insurers for all services provided. Diamond Head also collects some out-of-pocket payments from clients. In FY1993-94, the center ranked third in collecting revenues. As of March 31, 1995, Diamond Head ranked first overall for FY1994-95, with reported collections totaling $107,904.

Centers undertake initiatives

Increasingly, centers require billing revenues simply to sustain their current programs and to continue to properly serve their clients. Billing initiatives developed by the state centers underscore the growing importance of these revenues. Center personnel have attempted to remove some of the obstacles preventing the maximization of billings and collections by initiating work on standard policies and procedures, creating their own training opportunities, and taking the lead in seeking greater billing and reimbursement opportunities. These center-based initiatives are especially needed because the Adult Mental Health Division does not aggressively pursue billings and collections.

Billing clerks pursue policies and procedures

Standard policies and procedures are a basic requirement for improving the centers' billing and collection systems. For example, some centers indicate that they are not collecting out-of-pocket payments from clients because there are no standard policies and procedures for collections. Centers need to know when and how to collect fees directly from clients and when debts should be written off as uncollectible.

The lack of standard policies and procedures from the division to guide billings and collections continues to hamper the progress of the centers. However, on their own initiative the billing clerks recently revived their monthly meetings, which had been discontinued after July 1994. The purpose of the meetings is for the centers to share information on billing and to develop a standard billing manual for all centers.

The billing clerks' plan to develop a standard billing manual has gained the endorsement of the division. Division representatives now attend each meeting and the division has begun to establish a billing task force to create a billing manual. Representatives from the centers, the division, and the department's Child and Adolescent Mental Health Division will make up the task force.

Centers initiate training

State centers' personnel have also initiated their own training opportunities. The billing clerks use their monthly meetings for training purposes, by trying to resolve billing issues, problems, and questions. At their March 1995 meeting, the clerks discussed their billing problems and questions with a Medicaid representative. The clerks received direct responses to their concerns and the representative promised to clarify remaining questions. Another result of the meeting was a division request to the Department of Human Services to expand the number of billing codes under its Medicaid agreement with the Department of Health. The additional codes should result in more revenues for the centers by enabling them to bill for more clinic services. Previously, centers have been limited to codes that do not always apply to the particular clinic visits that occur at the centers.

The centers have developed other training opportunities. Leeward Oahu used a psychiatrist hired on a fee-for-service basis to advise its staff on Medicaid billing. This person—a former Medicaid consultant—trained staff on ways to legitimately bill Medicaid for more services and at higher rates. Such training could result in more revenues for the center because 32 percent of its clients have Medicaid coverage.

Windward Oahu received training from the same psychiatrist and initiated a meeting with two employees of the Med-Quest Division of the Department of Human Services, which handles the Medicaid and Health Quest programs. The meeting clarified billing issues and provided information on how to increase reimbursements.

Centers expand billing opportunities

The Windward Oahu center is taking the lead on expanding billing to more insurers. It spearheaded a drive for the centers to become

providers of services for the Hawaii Medical Service Association (HMSA) health plan under Health Quest. HMSA is one of five health plans providing coverage for basic health care under Health Quest. Health Quest serves clients who formerly were covered under certain other state health plans and new clients who qualify for Health Quest.

By becoming service providers under the HMSA health plan, the centers would be able to bill HMSA for services provided to center clients covered by the plan. The centers would service these clients under the plan on an emergency or interim basis before the clients are certified as seriously mentally ill and thereby qualify for a specialized health care plan under Health Quest called Behavioral Health Managed Care. The centers are already service providers under the Behavioral Health Managed Care plan, which is only for the seriously mentally ill.

Windward Oahu also plans to investigate becoming a provider for the Queen's health plan under Health Quest.

Furthermore, the Windward Oahu center also clarified with the Med-Quest Division of the Department of Human Services that a center as a whole can be designated as a client's case manager. Up until then, individual staff at the centers served as designated case managers and the centers could not bill for case management services provided by a staff member who was not the client's designated case manager. By having a center designated as the case manager, more case management services will be billable.

In connection with this initiative, the Windward Oahu center has developed policies and procedures for various levels of staff who perform case management services. Center representatives commented that these procedures have been forwarded to the Adult Mental Health division for approval and division-wide implementation.

Special fund ceilings need re-evaluation

Increased revenues resulting from these initiatives and other improvements should increase the balance in the special fund that holds the centers' billing revenues. Within the legislative appropriation for the special fund each year—which in effect establishes a limit on expenditures from the fund—the division has imposed a ceiling on expenditures on each center's subaccount within the special fund account.

These subaccount ceilings are based on revenue projections made when the Legislature created the special fund in 1991. But some centers' billing revenues have apparently outgrown the 1991 projections. As a result, deposits for three centers exceeded their respective ceilings as of March 31, 1995. For example, Kauai County's subaccount listed a

balance of $156,221 while its expenditure ceiling is $53,700 per year. This means that more than $100,000 in billing revenues could not be expended by this center for FY1994-95. The Adult Mental Health Division needs to re-evaluate the respective subaccount ceilings within the legislative appropriation for the special fund, so that the centers will not be discouraged from pursuing revenues.

Conclusion

The state-run community mental health centers have implemented billing and collection systems and are steadily increasing their revenue recoupment. However, we believe that billing revenues could be significantly increased by eliminating obstacles to maximization. The division needs to develop a standard billing and collection system for the centers, including proper automation, policies and procedures, and an ongoing training program.

Some state centers' staff also need to increase their commitment to billing. Billing must be a top priority for all staff because these revenues are needed to help ensure the continuation of current services. All center chiefs should provide leadership and take responsibility for encouraging staff to consistently bill. All the chiefs also need to institute management controls—as some have already done—to ensure that staff follow all procedures for billings and collections.

The Adult Mental Health Division should make subaccount ceiling adjustments as needed while abiding by the overall special fund ceiling. To the extent possible in the State's current budgetary situation, the division should also assist the centers in filling vacant positions that affect billings and collections.

The division needs to take an aggressive, activist approach to maximizing revenues for the centers. We discuss this in more detail in the following section.

Adult Mental Health Division Does Not Aggressively Pursue Billings and Collections

The Adult Mental Health Division has the responsibility for the Department of Health's adult mental health programs, including its community mental health centers. The division maintains that billing is a high priority. However, we found that the division has not aggressively pursued billings and collections to increase the centers' revenues. It has provided no overall plan or guidelines, little formal training, weak oversight, and inadequate recordkeeping. The division is not pursuing all revenue opportunities, and lacks a billing coordinator. We believe that the division's inaction has significantly contributed to the obstacles, previously described, faced by the centers.

Division has overall responsibility

The division is responsible for the operations, services, activities, and facilities of the State's adult mental health programs, and must direct, coordinate, and monitor these programs. Its functional statement lists one of its duties as: "Establishes and maintains a system of charges for services based upon cost data, including billing, collection, write-offs, and controls of accounts receivable." Furthermore, an important element of its mission is "providing administrative and professional support to the community mental health centers."[2] But we found that the division does little to carry out these responsibilities in the area of billings and collections.

To maximize the centers' revenues, the division must take an aggressive, pro-active stance in dealing with insurers and the Department of Human Services, which runs the Medicaid and Health Quest programs. The division needs to represent and advocate the interests of the centers in negotiating billable services and pursuing payments with that department, and in determining what private insurance plans will pay for and how to best bill for these services.

Division lacks a plan, policies, and procedures

No overall plan or strategy currently guides the centers' billings and collections. At one time, planning efforts were concentrated at the level of the Behavioral Health Administration, above the Adult Mental Health Division in the Department of Health. The Behavioral Health Administration focused on the development of a billing policies and procedures manual. Completed in December 1991, this manual conceptualized a billing vendor and a centralized billing unit that would serve the division. But neither the administration nor the division implemented the proposed billing manual or any standardized policies and procedures for billings and collections.

As a result, the division has failed to provide needed guidance and support to the centers. Without an overall plan or standard policies and procedures, the centers have been left to fend for themselves in an area that is complex, and for which the centers do not have ready expertise.

According to the functional statement, the division is responsible for developing policies and procedures for third-party reimbursements, such as those from Medicare, Medicaid, CHAMPUS, the Veterans Administration, and private health insurers such as HMSA. But despite the division's responsibilities and its promises to develop policies and procedures for billing and collecting, these do not exist.

In FY1992-93, the division began to work on updating, developing, and standardizing policies and procedures across the division to establish a higher level of service. In the *FY1994-95 State Plan for Mental Health*, dated October 1994, the division acknowledged that policies and

procedures need attention. The division has only begun to use a billing task force whose duties include developing a plan for the division's billings and collections.

Division provides little training

The division has not provided sufficient training on a regular basis, to meet the job demands of centers' billing clerks. Formal training outside of the billing clerks' meetings has been sparse, which is particularly unfortunate because the billing clerks have little written guidance in the form of official policies and procedures.

We found only two documented billing and collection training sessions between February 1992 and March 1995 that were not a part of the billing clerks' meetings. Until she left at the end of 1994, the division's financial specialist (commonly referred to as the "billing coordinator") tried to train the billing clerks. The clerks informed us that the billing coordinator provided training and instruction on billing during the monthly billing clerk meetings. The billing coordinator would attend billing training sessions provided by insurers and pass on that information to the billing clerks at the meetings. The information was oral, not written, and did not satisfy all billing clerks.

Knowledgeable billing coordinator is needed

The division needs a qualified employee who can concentrate on carrying out its responsibilities for billings and collections. These include implementing policies and procedures and aggressively representing the division's interests in interactions with other state agencies or private insurance entities.

To maximize billings and collections, the division must have a good working knowledge of insurers' billable services, how to bill and collect, and pertinent agreements. In some instances, such as with Medicaid, interagency agreements directly affect what services can be billed and, ultimately, reimbursed. Each insurance program, whether government or private, has its own rules for billing. Particularly for private insurers, because of the differences in insurance plans, the billing clerks bill for all services or file claims by trial and error, or do not bill unless they are sure the claim will be paid. In some cases, clients have second or third insurance plans. Many questions and issues arise because of these complexities. The centers currently are taking the initiative to resolve these themselves.

It would be more expedient and effective to have a qualified, knowledgeable employee at the division level to serve as the billing coordinator within the division and advocate for the centers and division with outside parties. This person would answer to the division chief. The centers would have a resource person at the division level to provide

assistance and assume or coordinate the centers' initiatives. This person should also be able to evaluate the centers' progress in maximizing revenues.

From March 1988 until December 1994, the division's financial specialist, or billing coordinator, was responsible for overseeing billing efforts by the centers. However, due to the deletion of this position in December 1994, the division currently does not have an individual whose primary duty is to provide services to the division and the centers on billings and collections. These duties have been assigned to the division's acting public health administrative officer. However, in addition to administrative duties for the division, the officer is also handling the duties of the personnel management specialist position.

The financial specialist position, a temporary exempt position lasting six years, was eliminated on December 30, 1994. According to the departmental personnel officer, the position had a "not-to-exceed" status with an ending date of December 30. The division did not seek to remove this status. Furthermore, it appears that the division never asked the personnel office to pursue making the billing coordinator position a permanent civil service position.

According to the division chief, the division wanted to make the financial specialist position permanent, which requires reorganization of the division. The division used the representation that the division's reorganization was pending, to justify the final extension of the financial specialist's position to December 30, 1994. But no reorganization has been completed.

The department reports that a permanent position for a billing coordinator has been included in the division's fiscal biennium 1995-97 budget. We believe that this is a step in the right direction provided that the person filling the position will have the needed qualifications.

Oversight of billings and collections is weak

While the center chiefs are responsible for implementing billings and collections at their respective centers, the division is responsible for monitoring all billings and collections. Currently, since the termination of the financial specialist position (billing coordinator), no one at the division provides sufficient oversight to ensure that the centers bill for their services. When the division had a billing coordinator, the division regularly received monthly reports on amounts billed and collected from the centers. It is not clear whether the division still requires the reports, and some centers do not submit them. The absence of periodic reviews and evaluations by the division of the billings and collections of the centers undermines the division's stated commitment to maximizing billing revenues.

To carry out monitoring, management controls are needed at the division level to ensure that billings and collections are maximized and to assess when and how to assist the centers. Management controls should include reports from the centers, and evaluation of the data in the reports and the data collected at the division level. The division should also conduct periodic reviews of records at each center.

Important records are missing

The division's lack of commitment to and weak oversight over billings and collections is further demonstrated by its inability to readily locate important records. The division has no copy of the master agreement with the Department of Human Services on Medicaid. Correspondence and memoranda on billings and collections are scarce. These records are not, but should be, readily available if the division is to be serious about maximizing centers' revenues. It is difficult to actively pursue reimbursements without the basic enabling document and other records that provide the parameters for obtaining reimbursements.

For example, the billing clerks discovered how to request the use of additional billable Medicaid procedure codes under the Medicaid agreement at a billing clerks' meeting at which a Medicaid representative from the Department of Human Services was present. The Medicaid agreement could have earlier alerted the division and the billing clerks of this avenue if the division had a copy. Additional billable codes are needed to compensate the centers for the actual type and length of services they provide. It was not until the March 1995 billing clerk meeting that the division and the clerks learned that the agreement allows the division to request additional Medicaid procedure codes in writing. The division has submitted a letter to the Department of Human Services requesting additional Medicaid procedure codes.

Division is not actively pursuing reimbursements from Department of Human Services

The division has not aggressively pursued reimbursements under its agreements with the Department of Human Services in order to maximize the receipt of these revenues by the centers. Significant examples of the effects of this failure include limited billable procedure codes under the Medicaid agreement, delay in receiving reimbursements for services provided by the centers during transition into the Behavioral Health Managed Care plan under Health Quest, and delay in receiving reimbursements for services provided by the centers under the managed care plan.

Medicaid is very important to the division. All of the community mental health centers are billing Medicaid. As of April 1995, approximately 34 percent of the centers' total number of clients were insured by Medicaid. Medicaid accounted for nearly 63 percent of the centers' deposits as of the third quarter of FY1994-95. Yet the division only recently learned

how to properly request the use of additional billable procedure codes from the Department of Human Services. Obtaining this authorization will increase revenues.

Another example is the agreement between the two departments for providing mental health services to the seriously mentally ill during the State's transition into the Behavioral Health Managed Care plan. The managed care plan took effect on November 1, 1994. Between August 1, 1994 and October 31, 1994, people who qualified for Health Quest were in the process of being identified as seriously mentally ill for placement under the managed care plan. During this transition period, the centers were servicing these clients and the Department of Human Services agreed to pay the Department of Health a case rate amounting to $410 per person each month. This agreement limited the number of clients to 500 each month. The maximum reimbursement could have been as high as $205,000 each month during the transition. But the division did not aggressively pursue reimbursement for services provided during this period.

The agreement stipulated that a monthly invoice be submitted to the Department of Human Services for services provided by the centers. However, instead of a monthly invoice, the division submitted a single invoice on January 27, 1995—nearly three months after the termination of the agreement. Over two months later, the division sent a letter to the Department of Human Services regarding the status of the invoice. The division finally received payment of $484,210 on April 21, 1995—nearly six months after the termination of the agreement. The delay meant that the centers lost the use of this money for more than six months. (The division's casual approach in pursuing these reimbursements was foretold by earlier events. The agreement was signed over two months after its effective date—only 17 days before the termination date.)

A third example is the division's handling of reimbursements after the Behavioral Health Managed Care plan took effect. The division has not aggressively pursued reimbursements for services provided by the centers from November 1, 1994.

The Department of Human Services contracted with HMSA to implement the managed care plan. HMSA subcontracted with another organization to run the plan, which HMSA calls "Community Care Services," from November 1, 1994 to June 30, 1995. HMSA has invoiced the Department of Human Services on a monthly basis under its contract, and has been paid for clients served since November 1, 1994.

While the centers are the actual providers of services for the seriously mentally ill under the managed care plan, the Adult Mental Health Division must request reimbursements for these services from HMSA. However, the division has not aggressively worked on finalizing the

centers as providers under the program through a binding contract with HMSA, or on securing reimbursements from HMSA. Although the time frame for the agreement is November 1, 1994 to June 30, 1995, the contract between the Department of Health and HMSA has been only in draft form. Under the draft contract, HMSA would reimburse the division on a case rate basis of $410 per person per month. But as of May 1, 1995, near the end of the agreement period, neither the contract nor a letter of agreement had been signed.

Also, as of May 1, 1995, the division had not asked for reimbursements. HMSA informed the division that under a "good faith" verbal agreement, HMSA will pay the division once it receives an invoice for an approved list of clients (many of the clients were previously covered by Medicaid). HMSA conservatively estimates that 300 clients are receiving services from the centers. The value of these services under the case rate is $123,000 per month. But the division has yet to submit any invoices for services provided by the centers.

Delays have been attributed to HMSA's requirement that there be an agreement on the seriously mentally ill clients covered under the plan. Although HMSA is invoicing and receiving payments from the Department of Human Services for these clients, HMSA is requiring that the centers verify the status of these clients before paying the centers through the division.

The Waianae center must have its own agreement with HMSA under the managed care plan because it is a private organization. HMSA informed us that Waianae has received payments from HMSA. Waianae has signed a letter of agreement and has invoiced HMSA. As of March 1995, HMSA has reimbursed Waianae for services provided in November and December 1994 and January 1995.

Other opportunities for increased billings and collections exist

Besides pursuing reimbursements under the human services health programs, the division and its centers have opportunities to increase revenues by billing private and other insurers and collecting payments directly from centers' clients. These opportunities should be pursued.

As of April 1995, about 14 percent of the centers' clients had private insurance. CHAMPUS and the Veteran's Administration accounted for another 0.5 percent. The centers' deposits from these insurers ranged from nothing to $30,108 in FY1993-94. In that year, four centers did not collect at all from private insurers, CHAMPUS, or the Veteran's Administration. As of the third quarter of FY1994-95, only two centers did not collect from these insurers. The centers' deposits from these insurers through the third quarter of FY1994-95 ranged from $0 to $21,148.

Collecting payments directly from the centers' clients is another opportunity for the division to increase collections. Some clients can and will pay for the services that they receive. But the division does not have a policy on billing clients for copayments, deductibles, and noncovered services, nor on writing off uncollectible amounts.

Four centers do not attempt to collect copayments, deductibles, or payments for noncovered services from patients. Some billing clerks report that this is due to the lack of a standardized collection policy from the division. While other centers have collected payments from clients, only Kauai is consistently attempting to do so.

Centers should collect such payments from clients who can pay for the services they receive. The division has no justification for not adopting official policies and procedures on billing and collecting fees directly from clients. Centers should have guidance on when and how to collect fees directly from clients and on writing off debts of clients who cannot afford to pay or can make only partial payments.

Conclusion

The Adult Mental Health Division appears to have the desire to increase the billings and collections of the centers. It also appears that the division's top priority is to obtain national accreditation of outpatient mental health services by the Commission on Accreditation of Rehabilitation Facilities. The division's effort to attain accreditation for the centers is important and should continue. Nevertheless, the division needs to adopt an aggressive, pro-active role in billings and collections and assume its responsibilities in guiding, supporting, and monitoring the centers' efforts in order to substantially increase their revenues.

An important means of maximizing billings and collections is the installation of appropriate hardware and adequate billing and collection software. As discussed below, the division's lack of aggressive activity and commitment to billing is underscored by its failure to follow through on an earlier attempt to contract with a private vendor to handle billings and the uncertain status of the attempt to obtain appropriate billing software.

Inadequate Automation Presents a Major Obstacle

Billing and collecting is time-consuming, labor-intensive, and potentially discouraging without the proper automation. The process includes obtaining information on the client's insurance coverage and the type of service provided, translating this service into the proper service (procedure) code (which varies with insurance companies), completing

and mailing the claim form, and documenting information on the services and dates on which services were provided, claims were submitted, and reimbursements were received.

In the private sector, these steps in the billing process have largely been automated, which can result in a virtually paperless system. Since the state community mental health centers have limited automation, they still manually log information on clients and manually complete most claim forms. This considerably slows the billing process and affects the centers' revenues.

The Adult Mental Health Division needs to ensure that billing software is integrated with an information system and includes, but is not limited to, the following criteria (capabilities):

- track, display, and report the history of each client's mental health and medical treatment;
- transmit billing information and receive remittance files electronically, and post payments, adjustments and write-offs;
- print HCFA 1500 forms as well as other claim forms for non-electronically processed claims;
- print billing statements for clients; and
- produce standard and ad hoc evaluation reports and information on billing statuses for planning purposes.

Appropriate hardware should support the software package on an on-line system, centralized at the division.

Problems exist with both hardware and software

The quality of hardware and software at each of the eight state community mental health centers varies greatly. The older, less advanced hardware at most centers affects the amount of time it takes to process claim forms and to enter, retrieve, and update data. According to a list provided by the data systems unit of the Adult Mental Health Division, a majority of the centers still use outdated 286 or 386SX Wang personal computers, which are slow in processing and are no longer manufactured. (On the other hand, one center has a state-of-the-art personal computer that was donated.)

The lack of appropriate software also hampers the centers' ability to maximize billings and collections. The division uses a makeshift software package not originally intended for billing purposes. The data systems unit developed the software in 1993 to meet a legislator's

request for a monthly revenue report. The centers used this database program as a patient accounts receivable system for the purpose of collecting and maintaining billing and collection statistics for the report.

As a billing tool, the software is able to print out HCFA 1500 claim forms but cannot print out billing statements that are needed to bill patients directly. The software requires constant re-tooling to meet the centers' billing requirements.

Also, this software is not integrated with the division's management information system—the Mental Health Field Assessment and Statistical Information System (MFASIS)—or with electronic claims processing software used to file claims with insurers such as Medicare. The lack of integration with MFASIS means that it is difficult to evaluate services provided with respect to services billed and collected for, since reports from two separate computer systems—MFASIS (for services) and the billing software (for billing information)—would need to be generated. Yet such an evaluation could be a valuable management tool.

The current process requires that information on clients be separately entered into MFASIS and the billing software. Further, to do electronic processing of claims, the billing information must be entered onto a disk or the computer must be hooked up to a modem and billing information must be entered again. Thus, to do electronic processing, a third data entry (after entry into MFASIS and the data systems unit's billing software) is required. Because of this inefficient situation, two centers chose not to use the billing software and some of the centers do not use electronic processing.

Billing clerks who manually process claims must spend more time processing the claim forms than if they were to electronically send the claims to the insurer. This contributes to a processing backlog for reimbursements from Medicare and some private insurers who allow electronic processing.

An example of an integrated billing software system is the new Patient Management Information System (PTMIS) created by the Waianae Coast Community Mental Health Center, Inc. The system is currently being developed by a computer programmer who volunteers his time. PTMIS consists of two main databases. These are the PTMAST, which includes client identification and demographic data (like the data collected in MFASIS), and the PTVIS, which provides information on the service provided to the client, duration of the visit, service provider, and location of the service. Data from these two main databases provide information for several sub-databases: patient intake, patient medication tracking, patient financial assessment, case management, and billing.

Division has not met state centers' computer needs

The division's data systems unit is responsible for the centers' computer needs. The department's functional statement says that the unit must operate and maintain a data system to collect and process statistical data. It also must provide consultation, technical assistance, and training on methods and forms of the data system.

Despite this responsibility, the division has provided only one resource person to assist all of the centers. This individual developed and is responsible for maintaining the current billing software program. He must visit each of the centers to make program modifications and solve problems. However, one of the centers on Oahu has complained that since it is located far from the division, it is last on the list when it comes to being serviced. One neighbor island center indicated that it is not serviced at all.

The division also has not ensured that all of the centers have access to comparable computer hardware and software. To begin with, billing clerks have had the *option* to use the division's billing software and two centers have chosen not to use it at all. Also, because of the varying hardware capabilities, the efficiency of the billing processes has been affected and some centers have the ability to produce more detailed reports than others.

These reports, if standardized, could produce useful planning tools for the division. According to the division, it has not made efforts to develop these reports with the current billing software.

The current software was supposed to serve as a short, interim solution while other proposals were pending or being implemented. Plans for a billing vendor were developed, but not carried out. A request for proposal for an integrated billing software package is in the hands of the department's administrative services office. Due to budget restrictions, it is currently stalled.

RFP for billing vendor not implemented

In early 1992, the director of the health department told the division that it should contract with a vendor for billing. He felt that there were not enough people or expertise in the division for billing and collections. A study conducted by a certified public accounting firm—Ernst & Young—developed this idea.

A committee that included the heads of the division's research and statistics and data systems units, the chiefs of the Diamond Head and Kalihi-Palama community mental health centers, and support staff from both the division and the department's Child and Adolescent Mental Health Division met with three vendors and evaluated the services of

each vendor to help determine the services desirable in a billing vendor. A request for proposal was developed by the committee in February 1993.

The Department of Budget and Finance returned the draft request for proposal with concerns and questions that it wanted the Department of Health to address prior to approval. However, the department did not continue the process.

RFP for software stalled

More recently, the division decided to research billing software options for a computerized billing system because one of the requirements of a consent decree against the Child and Adolescent Mental Health Division, in a federal lawsuit titled *Felix* v. *Waihee*, is a compatible data system among agencies. The research and evaluation staff of the adult division developed a questionnaire to solicit the input of the center chiefs on potential systems. The adult division invited the children's division to participate in answering the questionnaire.

The adult division used the questionnaire in developing a request for proposal for an integrated billing software package; however, its efforts have been stalled. The request for proposal is now pending in the department's administrative services office due to budget restrictions. Also, it is unclear what funding mechanism would be used for the request.

Since the billing vendor option is dead and the current billing software was not intended for billing and has limited capabilities, the Adult Mental Health Division should make the purchase of an appropriate billing software package a priority. However, before making a purchase, the division must ensure that the software's quality is proven, the requirements are clearly defined and mutually understood, and the format and content of the detailed design is established.

Conclusion

Adequate automation is sorely needed to enhance the state centers' ability to maximize revenues from billings and collections. Even if all other recommendations in this report were implemented, the centers could not be expected to fully maximize revenues without appropriate computer hardware and software. Good automation would work hand in hand with other recommendations to fully realize the centers' revenue potential. The division will need to provide training on how to use both the software and hardware and provide adequate support to centers for computer problems or queries.

Recommendations

We recommend the following:

1. The chiefs of the state-run community mental health centers should make maximizing billings and collections a top priority.

2. The chiefs of the state centers who have not already done so should implement management controls to ensure that staff complete all necessary procedures, forms, and records necessary for billings and collections.

3. The Adult Mental Health Division should re-evaluate and adjust the centers' special fund subaccount ceilings within the legislative appropriation for the special fund.

4. The division should adopt an aggressive, pro-active role and assume its responsibilities in guiding, supporting, and monitoring the community mental health centers' billings and collections. Specifically, the division should:

   a. plan and implement a division-wide, overall billing system for the state-run community mental health centers that includes proper automation, standard policies and procedures, management controls, and an on-going training program;

   b. designate a qualified staff member to concentrate on implementing the division's billing and collection responsibilities, who would serve as a resource person, coordinator, and advocate for the division and the centers; and

   c. maintain proper documentation and historical information crucial to the division's billing and collection efforts.

5. The division should purchase an integrated billing software package that will meet at least the requirements that we have identified, and should provide ongoing training and technical support for the software package. The division should also install comparable hardware at all of the state community mental health centers to support an on-line, integrated billing system for all centers.

Notes

Chapter 1

1. Hawaii, Legislative Reference Bureau, *"Reinventing" Governance of Hawaii's Public Mental Health Delivery System—Problems, Options, and Possibilities*, Report No. 5, Honolulu, 1994, p. 79.

Chapter 2

1. Hawaii, Legislative Reference Bureau, *"Reinventing" Governance of Hawaii's Public Mental Health Delivery System—Problems, Options, and Possibilities*, Report No. 5, Honolulu, 1994, p. 79.

2. Hawaii, Legislative Reference Bureau, *Guide to Government in Hawaii—Tenth Edition*, Honolulu, May 1993, p. 67

Responses of the Affected Agencies

Comments on Agency Responses

We transmitted a draft of this report to the Department of Health and the Waianae Coast Community Mental Health Center, Inc. on October 17, 1995. A copy of the transmittal letter to the Department of Health is included as Attachment 1. A similar letter was sent to the Waianae center. The department's response is included as Attachment 2. The Waianae center did not submit a response.

The Department of Health said that, overall, it is in agreement with the report's findings and recommendations. It said the report seems objective and fairly presented.

The department also commented on certain statements in our draft report and requested some changes. We made a few revisions in our final report to address some of the department's factual concerns.

The department also provided an update on its efforts to procure integrated billing software and informed us that it is considering requesting an increase in the special fund ceiling. The department says that its FY1994-95 revenue-generating activities at the centers recouped $1,195,019 in reimbursements, which is a 250 percent increase over the prior year's revenues. This total is not included in our exhibit on revenues because our fieldwork had concluded before all FY1994-95 revenue figures were available. We find the information on software and revenues encouraging and urge continued efforts to increase reimbursements.

ATTACHMENT 1

STATE OF HAWAII
OFFICE OF THE AUDITOR
465 S. King Street, Room 500
Honolulu, Hawaii 96813-2917

MARION M. HIGA
State Auditor

(808) 587-0800
FAX: (808) 587-0830

October 17, 1995

COPY

The Honorable Lawrence Miike
Director
Department of Health
Kinau Hale
1250 Punchbowl Street
Honolulu, Hawaii 96813

Dear Dr. Miike:

Enclosed for your information are three copies, numbered 6 to 8 of our draft report, *Audit of the Management of Billings and Collections for the Department of Health's Outpatient Adult Mental Health Services*. We ask that you telephone us by Friday, October 20, 1995, on whether or not you intend to comment on our recommendations. If you wish your comments to be included in the report, please submit them no later than Tuesday, October 31, 1995.

The Waianae Coast Community Mental Health Center, Inc., Governor, and presiding officers of the two houses of the Legislature have also been provided copies of this draft report.

Since this report is not in final form and changes may be made to it, access to the report should be restricted to those assisting you in preparing your response. Public release of the report will be made solely by our office and only after the report is published in its final form.

Sincerely,

Marion M. Higa

Marion M. Higa
State Auditor

Enclosures

BENJAMIN J. CAYETANO
GOVERNOR OF HAWAII

LAWRENCE MIIKE
DIRECTOR OF HEALTH

34755

STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. BOX 3378
HONOLULU, HAWAII 96801-3378

November 1, 1995

RECEIVED
Nov 1 3 39 PM '95
OFC. OF THE AUDITOR
STATE OF HAWAII

TO: Marion Higa
State Auditor

THROUGH: Lawrence Miike
Director of Health

THROUGH: Sherry Harrison
Acting Deputy Director

FROM: Malina Kaulukukui
Acting Chief, Adult Mental Health Division

SUBJECT: Draft Report: "Audit of the Management for the Billings and Collections for the Department of Health's Outpatient Adult Mental Health Services"

Thank you for the opportunity to provide feedback to the above draft report. Overall, the Adult Mental Health Division is in agreement with the report's summary and findings as well as its recommendations. Despite some factual errors which don't alter its basic findings and conclusions, the report seems objective and fairly presented. Center personnel are given due credit for pursuing billing activities despite a number of obstacles.

Specific comments on the report is as follows:

Page 2, paragraph beginning, "The Behavioral Health Services Administration . . ."

- The name has been changed to Behavioral Health Administration.

- Program ID HTH 420 only includes the eight centers and POS.

Page 3, paragraph beginning, "The contract with the Wai'anae Coast Community Mental Health Center . . ."

- Funding for FY 1994-95 was $1,177,035 with $650,385 budgeted for adult services.

Page 4, paragraph under "Special fund"

- In FY 96, the special fund ceiling was reduced to $564,146.

Page 8, paragraph beginning, "However, a Legislative Reference Bureau (LRB) report, . . ."

- The alleged statement by one legislator is global and factually inaccurate. The Department of Health's commitment to pursuing Medicaid billing was based on a number of factors. Since this paragraph lends no substantive credibility to the report, please consider deleting the entire paragraph.

Page 15, paragraph beginning, "To correct this situation . . "

- "the clinical clerical staff compare progress notes . ." should be changed to read "the clerical staff . . "

Page 17, paragraph beginning, "The billing clerks' plan to develop a standard billing manual . . ."

- The Division drove the initiative to develop a standard billing manual, but the billing clerks were instrumental in developing the process by which this would be accomplished.

Page 22, paragraph beginning, "A permanent position for a billing coordinator . ."

- A permanent position for a billing coordinator **is** included in the Division's fiscal biennium 1995-97 budget. The vacant research statistician position, which was intended to be designated as the billing coordinator, was abolished as of September 30, 1995 as part of the Division's budget restrictions.

Page 24, paragraph beginning, "Another example is the agreement between .. ."

- The Department of Human Services (DHS) pays the Department of Health (DOH) a "case rate", not a capitated rate. While the agreement limited the number of clients to 500 each month, only about 390 clients were **eligible** for the QUEST carve-out plan during the period in question. In fact, the centers **did** aggressively bill for services provided during this period, and recouped $484,210 in reimbursements.

Page 24, paragraph beginning, "A third example of . . ."

- The Division **has** pursued **case rate** reimbursements from November 1, 1994. As per agreement between DHS and DOH, centers submitted billings in the form of HCFA 1500s from November 1, 1994 through March 31, 1995. A total of $267,320 in reimbursements were received. The centers continue to submit monthly HCFA 1500 forms for all QUEST clients under Community Care Services.

Page 25, paragraph beginning, "Also, as of May 1, 1995 . . ."

- This paragraph draws confusing, inaccurate conclusions which have been previously discussed on page 24, and commented upon in this memo. The parenthetical information about many clients being previously served by Medicaid is confusing, as Medicaid/SSI clients are currently **excluded** from QUEST. Please consider deleting this entire paragraph.

Comments on Recommendations:

- Recommendation #3:

  The Division is currently evaluating the feasibility of submitting a supplemental budget request to increase the special fund ceiling. However, before a budget request can be finalized, revenue projections must be updated. The updated revenue projections must consider the effects of reduced center staffing due to budget reductions, possible changes to the Medicaid and Medicare programs, and the implementation of the new Behavioral Health Management Information System (BHMIS).

- Recommendation #4a:

  An RFP for a Behavioral Health Management Information System (BHMIS) was issued on September 5, 1995. Proposals were due by October 16, 1995. The proposals are currently being reviewed by a committee comprised of data systems, program and billing personnel. The Billing Task Force, whose purpose is to develop standard policies and procedures, will reconvene meeting beginning in November 1995.

- Recommendation #5:

  The BHMIS RFP will include integrated billing software and training and technical support. Hardware will also be purchased before the BHMIS is implemented.

As an epilogue, the FY 95 revenue-generating activities in the centers recouped $1,195,019 in reimbursements, which is a 250% increase over the previous year's revenues.

Again, thank you for the opportunity to comment on this draft. If you or your staff would like to discuss any of my comments, please feel free to call me at 586-4780.

DEPARTMENT OF HEALTH
ADULT MENTAL HEALTH DIVISION
REVENUES COLLECTED
FY 94, FY 95, FY 96

11/01/95
2149B

REVENUE SOURCES	FY 94 ACTUAL	FY 95 ACTUAL	FY 96 ACTUAL 7/95–9/95
Medicaid	231,697	420,049	202,536
Self–Pay	3,012	25,594	6,375
PASARR	10,920	4,200	2,940
Medicare	47,682	201,381	92,436
CCS	0	0	269,796
QUEST/DHS	0	484,210	0
Other	44,898	59,585	13,810
TOTAL	338,209	1,195,019	587,893